King County

Health and Human Services Transformation Panel

Meeting #4: April 24, 2013

1:00 PM to 4:00 PM

Mercer Island Community and Event Center
8236 SE 24th Street, Mercer Island

Panel Member Attendees:
Heidi Albritton, Seattle Human Services
Elizabeth Bennett, Seattle Children's Hospital
Dan Murphy for Jane Beyer, Washington State Department of Social and Health Services
Jim Blanchard, Auburn Youth Resources
Elise Chayet, Harborview for Dr. Dan Lessler
Colleen Brandt-Schluter, City of SeaTac, Human Services
Lisa Cohen, Washington Global Health Alliance
Merril Cousin, King County Coalition Against Domestic Violence
Deanna Dawson, Sound Cities Association
David Downing, Youth Eastside Services
Bill Hallerman, Catholic Community Services
Dr. Jeff Harris, Health Promotion Research Center
Patricia Hayden, Seattle-King-Snohomish YWCA
Ron Jackson, Evergreen Treatment Services (Ret)
Hyeok Kim, International Community Development Association
Emily Leslie, City of Bellevue
Sara Levin, United Way of King County
Marilyn Mason-Plunkett, Hopelink
Mark Okazaki, Neighborhood House
Nathan Phillips, South King Council on Human Services
Terry Pottmeyer, Friends of Youth
Kelly Rider, Housing Development Consortium
Mark Secord, Neighborcare Health
Janet St. Clair, Asian Counseling and Referral Service
Margaret-Lee Thompson, Developmental Disabilities

Excused:
Shelley Cooper-Ashford, Center for Multicultural Health
Julie Lindberg, Molina Healthcare of Washington
Adrienne Quinn, Medina Foundation
Diane Sosne, SEIU
Brian Knowles, Bailey Boushay House

Dr. Dan Lessler, Harborview Medical Center

Other Attendees:
Judy Clegg, Clegg and Associates
Susan McLaughlin, King County Department of Community and Human Services
Janna Wilson, Public Health of Seattle-King County
Betsy Jones, King County Executive's Office
Carrie Cihak, King County Executive's Office
Michael Gideon, King County Executive's Office
Kelli Carroll, King County Council Staff
Jay Parales, King County Council Staff
Ann Burkland, King County Council Staff
Jackie MacLean, King County Department of Community and Human Services
Terry Mark, King County Department of Community and Human Services
Greg Ferland, King County Department of Community and Human Services
Sherry Hamilton, King County Department of Community and Human Services
Karen Spoelman, King County Department of Community and Human Services
Jennifer DeYoung, Public Health of Seattle-King County
Kirsten Wysen, Public Health of Seattle-King County
Chrissy Russillo, Public Health of Seattle-King County
Suzanne Pak, Immersion Force
Harry Hoffman, Housing Development Consortium
Lindsay Drive, SEIU Healthcare
John Freeman, Pragmatic Associates
Julia Strekalovsky, Seattle Human Services Coalition

Meeting Summary

- Welcome, Introductions
- Timeline & Process Check
    - Plan to request extension from Council to allow for one more meeting on May 22nd, finalize plan and work on implementation plan. Plan is to have public comment period and then transmit to the Council by late June
- Overview for the Day
    - Purpose is for panel to share their ideas and concerns. Edits and improvements to language changes should be emailed to the team
- Review and Feedback on Plan
    - Motion Requirements
        - Calls for County Executive to develop a plan for an integrated, accountable system of health, human services, and community-based prevention
        - Vision and goals

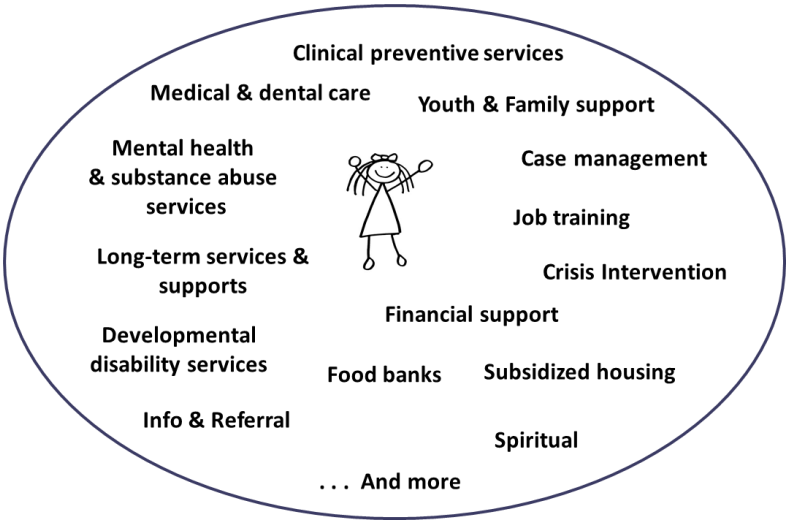
- Implementation strategies and plan
- Coordination with existing policies
- Performance measurement
- Strategic investments and financing options

- County Status
  - When you look at whole country -- life expectancy by county -- you can see KC highest average LE – among best in nation. We see predictably lower LE counties in the southeast. So it would appear we are doing pretty well here.
  - But, if we take a closer look at that same information by census tracts, another story comes to light. We can see some areas of the county have phenomenally high LE – over 92 years- while others have far lower life expectancies. This paints a very different picture of KC when we look at these smaller areas. And these similar patterns hold true with other outcomes as well – things like obesity, alcohol related deaths, quality housing, and smoking. The spread within our county is greater than the differences across all counties in the US.
  - US Spends the most on care -- Shows very clearly what poor value we are getting from our health care system b/c we are clearly different - an outlier. US is spending twice as much, basically, as other developed countries. Tragically, our LE is not among the highest.
- Low spending on social services relative to health services
  - Look at the ratio of social to health expenditures for developed countries. US is an outlier here as well. Now let me tell you what this means. Shows relatively drastic underinvestment in social services, and overinvestment in health care services. It's a factor for us because we want to work on SDOH and human services. There are only 2 countries that spend less than a dollar for dollar in health care to social services – US & Mexico. All others spend more on social services than they do on health care. The developed country average is 1.60 for social services, for every 1.00 they spend on health care services. In the US, we spend 80 cents in social service for every 1.00 we spend in health care.
- Feedback from previous version of plan
  - Goal should be more dynamic and "speak to people"

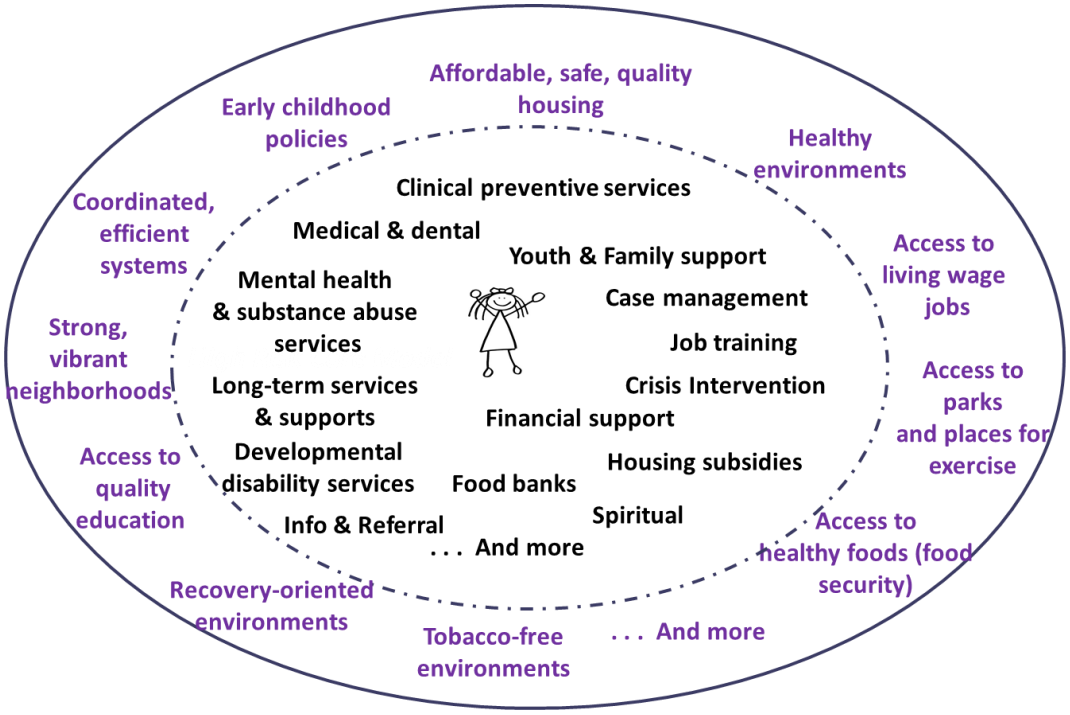
- Draw out focus on reducing disparities and need for cultural competence
- Look to language in King County Strategic Plan
- Too health care focused—broaden the language
- Needs to convey importance of strengths based approaches
- Add principle about being more adaptable

- Vision, Goal & Principles
  - **Vision:** All people in King County have the opportunity to thrive and reach their full potential
  - **Goal:** By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities
  - Principles in a nutshell
    - Be clear about outcomes
    - Individuals and families at the center
    - Be equitable; eliminate racial & ethnic disparities
    - Build on strengths to foster self-determination
    - Assure capacity, quality, & cultural competence
    - Be efficient
    - Prevent health and social challenges in the first place
    - Be adaptable
    - Achieve financial sustainability for the system
    - Build bridges across health and human services, public health, and community development
  - Broad Vision Individuals & Families at the Center…working across areas and preferences to align around what the person and family wants and needs
    - This girl in the egg reflects the world of health and human services providers delivering an array of integrated services. You see examples here of the health and social supports she may need for her health and well-being.

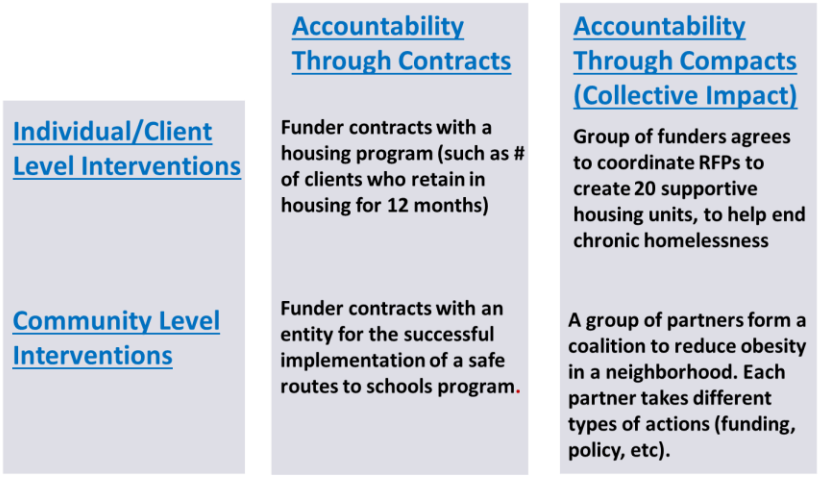
- Much of the integration work here is about shifting and reorienting delivery system to consider the whole person, place them at the center of the team, organize around the person's goals, preferences, cultural traditions, values (versus a historical focus on deficits and problems).
- Duals demonstration is an example of working to integrate care & social supports across these domains.



- But focusing on services to individuals not enough to improve health & well being and get us to version 3.0
- In addition to the set of integrated services that the girl needs we need a community system that maximizes the efficiency of those individual services and also provides community level services, policies that no single provider can provide that address the social determinants of health.
- So now, everything/everyone in the egg is what's needed to set the stage for working together to reach v. 3.0.



- System Improvement Through Two Levels of Work
    - Individual level interventions
        - "Whole person" approach (person-centered/patient-centered)
        - Focus is on access to range of integrated health, human services, & preventive services
        - High-impact integration strategies such as:
          - Medical & behavioral health integration
          - Multidisciplinary case management/teams for those with complex needs
        - Cultivation of transformed workforce, IT infrastructure
    - Community-Level Interventions
        - "Community-centered" approach
        - Focus is on improving community features (where people live, work, and play) that influence health and well-being
        - High-impact strategies such as
          - Place-based initiatives
          - Policy & system change
    - Integration & Cross-Sector Work: A Local Strong Suit (Examples)

- Individual Level
    - Behavioral health/primary care integration initiatives
    - Veteran's services integration
    - Domestic violence/sexual assault/behavioral health integration
    - Supportive housing units with on-site clinical, employment, & recovery supports
    - Youth-related – e.g., wraparound; homeless youth initiative; school-based health & human services
- Community-Level Interventions
    - Making Connections White Center/Seattle
    - Yesler Terrace - Choice Neighborhoods
    - High Point
    - Global to Local
    - Community Transformation Grant/Communities Putting Prevention to Work
- Accountability Mechanisms
    - 

    - We're thinking about the design as a 2x2 matrix. One axis is the individual / community levels of the interventions that are taking place to impact health & well-being. Accountability mechanisms are on the other axis – they are the tools we have to drive performance and integration. Much can and is accomplished through traditional contract provisions But when

multiple financing streams affect outcomes, we have to coordinate and assure accountability in a different way. Collective impact, a way of working across sectors to achieve outcomes that are collectively shared.

- So, within each box of this matrix, there are specific outcomes and activities that are supported to help reach them.

- Key Design Feature
  - Fewer silos among "individual" delivery level and "community" level work. **Instead**: a single, supportive structure to integrate across domains for planning, measurement, financing strategies, accountability.
  - Thinking back to the girl in the egg, need a "nest" that creates an environment for funders, organizations to work together to create the conditions that allow the individuals and families to thrive, get the services and community conditions that she needs for optimal well-being.

Comments and Questions

- **Q: Anything in the plan for ongoing funding for different approach and increased services**
- A: Coming later in the session today
- **Within principles, financial sustainability for the system – what does system mean? What's missing is clarity about unpacking what this means and to be able to make robust commitments. What also isn't clear is where data fits into the principles – we really need to talk about a data driven system of care. If we're talking data and sustainability, we have to invest in data infrastructure for entire system.**
- **We can't rob Peter to pay Paul and just shift money around. See page 36 reference to capacity – important to clarify this as a principle.**
- **Need a statement about engaging different regions and importance of regional responsibility and the roles of cities vs. counties.**
- **In reference to High Impact Strategies for those with greatest needs – the real need is for broad support for services beyond acute/emergency**
- **Agencies desire to treat the whole person, but the capacity and funding issues make this challenging**

- **Life expectancy appears to be heavily tied to income, so focus on racial and ethnic disparities may be misplaced**
- **Outer circle of egg shaped diagram does a nice job of making everyone accountable, beyond just health and human services but even roads, etc.**
- **Caution on use of Collective Impact and the associated time and effort. We may need to think of lower case ci rather than full blown CI**
- **What do we mean by well being? See WHO?**
- **Everything appears to be coalescing nicely in this draft.**
- **We may want to be explicit about having a principle of using disaggregated data.**
- **Where is the connection between the individual and program and population level approaches and outcomes? How will the Collective Impact approach address this?**
- **Need for attention to Medicaid funding in the ACA and the possibility of block grants; possibility of cuts in other areas to not have to cut Medicaid**
- **Crisis of current human service infrastructure does not come through clearly. This needs to be communicated more clearly –especially that the crisis predated the recession. What are the services that need to be available across the region? The plan has the opportunity to shore up these resources and not erode them further.**
- **Query on housing quality map and how the colors relate?**
    - More detail to come on this, and the final report will include a key
- **Goals appear to leave out WHO is going to experience gains in health and wellbeing – when raising the average, the focus can be on picking winners and losers. What happens to those who are just a little bit better than the worst and how do we pick the winners and losers.**
- **What accountability levels will be used where and how will the funding and contracting flow?**
- **Conversation around person and family is important.**
- **Programming, funding and policy choices need to be linked in the new integrated system**
- **Capacity issues – looking at other models there was a person serving as a linkage, bridge, coordination, liaison point**

- **Examples are enormously helpful, as what we are hopefully talking about is a new source of money. This report should say clearly what we need to do more of and what we need to do less of in the system. The examples help illustrate this.**
- **We do not know where the crises are in others' areas of the system – we need to be strategic about where we spend more money. It would seem that the things that are working are the areas that need to be addressed.**
    - **We need fewer unnecessary emergency room visits, etc.**
- **Report should call out next step of getting consumer engagement on where waste is in the system.**
- **Maybe give the girl in the picture a family, even a grandmother**

- Review and Feedback on Plan: Initial Strategies
    - Getting outcomes in our line of sight
        - Remind ourselves the Motion is about ***system*** transformation: improving the performance, integration, & accountability of the health, human service and community prevention systems for everyone
        - Remind ourselves of key principles - outcome focused, reduced disparities
        - Given the design elements, what's a way forward (not "pilots")?
    - A Way to Improve *Overall* HHS System Performance & Accountability
        - Improve system performance for *all* by focusing *first* on those people & places who most need that system to perform well. Leads to improved outcomes for those with the worst outcomes now – and a reduction in disparities. And tells us how well the system overall is doing (sentinel marker – a sort of watchperson)
        - The Motion is about system transformation. This is a strategy to improve overall system performance for all through a strategy of focusing on those who need it most
            - The most vulnerable (individuals and communities) are sentinel markers for how well the overall system is working -- taking the approach that the best way to get it to work for everyone is to make sure it's working for those who need it most.
            - Sentinel markers for how well the system is doing overall -

- Two proposed early strategies or areas of focus have been proposed to the Panel for feedback: in some ways, they are two sides of a coin
- Today there is extensive local focus in King County (locally as well as in Medicaid, Medicare) on highest users of health, social services, jail, ED, etc. Have an opportunity to create a more efficient, coordinated model of care for them that provides better value that lowers costs & improves health.
- Can apply that same construct to improving health and well being of communities -- just as we are focusing on people with indicators of high risk, high future spending, high complexities – we can focus on specific communities/zip codes where there are indicators that they are making disproportionate contributions to poor social and health outcomes.

- Individual Level Focus
  - **1. Improve outcomes for high need, high risk adults**
    - Fast-moving system changes - opportunities to coordinate in new ways for even more value & better client service
    - Some shared goals, investors, initiatives, & demonstrations already in play
    - Near-term opportunities to coordinate with State Medicaid
    - Risk of working at cross-purposes if we don't do anything
    - Can't achieve outcomes unless multiple sectors get aligned
  - **Why now?**
    - *State*: Medicaid Expansion, Dual Eligibles demo, Health Homes, managed care changes, HB 1519 (Accountability Measures), State transformation design work, mental health parity
    - *Hospitals*: Working on ED high utilizers & reducing readmissions
    - *Housing*: Permanent supportive housing interests
    - *Homeless response*: chronic homeless initiatives, HEARTH Act changes (HUD McKinney assistance)
    - *CJ System*: goals for reducing recidivism

- *County*: Public Health & DCHS policy goals & programs related to this group

- Community-level Initial Focus
  - **2. Improve outcomes for high need, high risk communities**
    - We have place-based initiatives to build upon (how do we make less *ad hoc*?)
    - Approach for tackling racial/ethnic and geographic inequities – and measuring change
    - Strategies *must* come from the community, be locally owned
    - Outcomes depend on multiple sectors getting aligned
  - **Why Now? Because . . .**
    - New recognition that among large metro areas, King County has some of the worst disparities
    - Can build upon initial recent successes and current efforts
    - Potential to leverage emerging opportunities (e.g., ACA hospital community benefit requirements; federal Medicaid/Medicare innovation grants?)
    - This work improves the overall system performance for everyone – by figuring out strategies to prevent and tackle problems earlier
- Sample Outcomes That Would Tell Us If the System is Working Better
  - *For this group of high risk people, achieve:*
    - Improved housing stability
    - Improved health status
    - Reduced CJ involvement
    - Reduced avoidable hospital ED use
    - Improved client satisfaction with quality of life
    - Reduced population-level health disparities
  - *For these communities, achieve:*
    - Improved housing

        - Increased employment
        - Reduced ACES scores (adverse childhood experiences)
        - Increased life expectancy
    - Focus on the people and the places with the greatest disparities

Comments and Questions

- **Community level portion of the report was cogent and solid**
- **Concern of stigmatization when talking about needs and assets in communities**
- **Many place based examples in report were urban centered, but need to be expanded to include suburbs**
- **One of the reasons we have high cost folks on an individual level is actually a system level failing.**
- **Maps are not capturing population density**
- **Notion of readiness also needs to be built into the report**
- **Language can become a bit "blame" oriented**
- **Focus of report appears too much toward adults**
- **Collective Impact efforts may require interim process as well as outcome measures**
- **Report reads as though addressing how large institutions will handle things, but at a community level, the real challenges are that the big systems need to change**
- **Community engagement generally starts with readiness and not just being told from the outside. There is a real need for outreach and development of political will and excitement**
- **Need for data sharing, and confidentiality and data protection including from subpoena**
- **Issue of burden on agencies to collect and report data – i.e., food banks and need to balance data collection issues**
- **Caution of unintended consequence of excluding those who are not big enough players to meet the mark**
- **Are service intensive adults reflective of the broader population? Many sub populations face different issues (immigrants access to benefits);**

gentrification and displacement – neighborhoods may not look the same in 20 years, but they may just be different people. How will a place based system account for this?

- **Looking for quick high money savings is not the same thing as deciding to forge a long term partnership with a community. Data can come with unintended consequences of creating "those" people who small communities are averse to.**
- **Investments in change need infrastructure – we can build bridges between siloes, but the foundations also need work.**
- **There needs to be a strengths based angle on these ideas. There is not a one hammer, one nail solution to things**
- **Listen to the communities we are serving**
- **Shared care plans are critical, despite data sharing concerns**
- **Will the implementation plan address which communities will get additional investment?**

- Review and Feedback on Plan: Financing Strategies and Next Steps
  - 1. Make best use of existing resources by defining outcomes and aligning resources to support the identified outcomes
    - Broad view of existing resources
    - *Over time*, shift from spending mostly on crisis & sick care to mostly on human services & prevention
    - By aligning with others around shared outcomes, get more value and open new doors to resources – it's not an agency by agency failing, but an overall system issue
  - 2. Leverage the opportunities provided under the Affordable Care Act
    - Health coverage expansion, including Medicaid
    - State Medicaid program - efforts to integrate care
    - Centers for Medicare & Medicaid Services Innovation Center opportunities
    - Occasional grant opportunities for behavioral health integration, community health center expansion, prevention, workforce, and more.
  - 3. Set the Stage for New Resources – shortfalls did not arise over night, and the resolution will also take time

- Assure adequate capacity in context of shifting to an outcome-driven system
- Anticipated that new revenue sources and tools will be needed to achieve the goal of this Plan
- Seeing and working on issues through a common lens can clarify gaps, solidify business case, and catalyze new investors

Comments and Questions

- **Boldness of plan disappears with discussion of setting stage for new funding. Everybody around the table agrees we need more funding. When we didn't name a figure for ending homelessness, we wound up 8 years down the road**
- **We need to state clearly that we need new revenue AND we need new revenue to shore up existing safety net services as a precondition to moving forward to transforming the system. Expanded funding from general fund has ended and all new funding is ear marked for narrow targeted funding streams often aimed at usual suspects. If we are saying public funding is only going for specific services and individuals, let's be honest about it and the rest of us can move on. Appears to read that new revenue is aimed at the new world order.**
    - Caution is that what we are suggesting is not a wholesale move into a new world order. Contracts and Compacts – the work we are proposing will gradually move into different strategies, but it won't be leaving people who are currently funded. We took note earlier to not redirect funding toward favorite initiatives. New revenue will not automatically go to new world order.
- **If we are going to talk about upstream savings and new funds, let's look at where those funds are going (criminal justice)**
- **Notion of revenue source being another sales tax for a specific population is a regressive tax that hits the population**
- **We need to commit today to the upstream work that needs to happen and shore up our human services and invest in quality programs**
- **We should say what our business case is, not that we need to develop a business case**
- **Can one of the pieces of the report talk about where we can do things differently? Opportunities coming from the ACA are NEW, if we just say we**

need more dollars, we are not positioning ourselves to show that we can do things differently. Policy makers need an opportunity to try something new

- **Can the report make clear that it is about transforming the system, not about the current shortfalls, but is instead a visionary look forward**
- **How will Medicaid expansion bring in more dollars? Are outcomes different for people on Medicaid?**
- **Does the report oversell the potential for ACA money? ACA is about expanding healthcare coverage and trying to address the cost of the medical care system. Related interventions are going to be focused on medical costs. This will not by any stretch be a pot of money for human services in the community.**
- **It's important to know what will be covered in the future. There will be significant new money for people who have been a drain on services. What will it pay for and who will be included? We need clarity on what Medicaid will pay for and what it won't. There is a further story to tell and some additional analysis needed. Access to coverage does not mean that all that we in this room provide will be paid for.**
    - We need to move below thinking about FFS Medicaid and instead look at how human services will be addressed as people move into managed care. We need to look at uninsured vs. insured
- **What's missing in the report is our role in shaping public policy and rule making. We need to be a voice into public policy.**
- **Ratio of funding of human services and health care is very intriguing – what would it look like if we got closer?**
- **Trigger phrases are worth noting – better use of existing resources, volume to value, outcomes**
- **Current system is under extreme pressure, and that does not come through in the report. Providers are operating in a near impossible environment. What will it take to get the ship righted, and then what is the next thing we can do for transformation? There are significant programs that were here five years ago and are gone today. Current system is very sick**
- **Talking about money cannot be a no no. Maybe we're not loud enough and too apologetic. It's not just the cuts we've taken, but continue to take, year after year. Will it take an implosion of the system to have this discussion?**

    - **How would collective impact be implemented, particularly the backbone, as it seems it would be a complex process.**
    - **We need examples of where we have aligned resources and leveraged dollars**
    - **We need to call out what we are going to measure our progress on**
    - **Who will be the neutral party to help convene implementation**
    - **Outcomes may be a catalyst for change, if believers commit to changing policy**
- Wrap Up and Next Steps
    - Get organized toward purposeful motion